



## **Written Testimony to the Little Hoover Commission regarding California Special Districts**

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The Association of California Healthcare Districts (ACHD) appreciates the opportunity to provide input to the Little Hoover Commission as it examines the role of special districts in California's future. We are pleased to offer our perspectives on the role and governance of Healthcare Districts in a changing health care environment, and to identify opportunities to strengthen delivery of health care services to millions of Californians.

79 Healthcare Districts serve the health care needs of millions of Californians in 40 counties in both urban and rural environments. Because Healthcare Districts were formed by local voters to respond to local health care needs, the services offered by Healthcare Districts are as diverse as the populations they serve. The range of services offered by Healthcare Districts are tailored to meet community needs and include prevention and public health programs to primary care, skilled nursing, ambulance, hospice, and acute and emergency services. Despite their unique and varied nature, the core mission of Healthcare Districts remains the same: to provide critical health services to the communities that created them.

Taken together, Healthcare Districts are a crucial part of California's health care system, with a growing role in achieving the goals of the federal Patient Protection and Affordable Care Act (ACA) and California's Medi-Cal expansion. Healthcare Districts play a vital role in communities with severe health care provider shortages, and are an integral part of California's health care safety net. In many cases, Healthcare Districts are the sole source of health and medical services for families and seniors.

Today, Healthcare Districts are innovating to deliver top quality services in a changing state and national health care landscape, with a focus on preventative and primary care. As the Triple Aim framework of the ACA is re-shaping health care delivery by targeting improvements to quality, cost, and population health, all hospitals and health systems are rethinking their approach to care, including services beyond the walls of the hospital. Accordingly, the non-hospital services delivered by Healthcare Districts will be increasingly important as Medicaid reimbursement shifts focus to value and outcomes over the next five years.

Healthcare Districts recognize that responding to the changing health care environment will require new approaches and new partnerships. With the goal of an enhanced understanding of the unique suitability of Healthcare Districts to deliver community needs and equipping Healthcare Districts to meet evolving federal and state mandates, ACHD is leading a statewide assessment, through a working group, of the role of Healthcare Districts in the health care environment. They are also considering public policy changes that will enable Districts to improve public engagement and governance. This working group is comprised of trustees and executives from

Districts around the state. Once our work is finalized, we plan to share our findings with the Legislature and stakeholders, including potentially seeking legislation in 2017.

## Overview and Brief History of California's Healthcare Districts

In 1945, in an effort to improve access to acute hospital care, the Legislature enacted the Local District Hospital Act. The legislation enabled a community, with voter approval, to form a special district and assess property taxes to support the construction and operation of hospitals and health care services, including ambulance services. With increasing recognition that public health strategies, prevention, and primary care are vital to community health and cost-effective in health care delivery, the Legislature broadened the scope of Hospital Districts and renamed them "Healthcare Districts" in 1994. Healthcare Districts are funded through a variety of revenue sources including: property taxes, special taxes, bond funds, insurance reimbursement, and Medi-Cal/Medicare reimbursement.

Healthcare District residents elect local boards to oversee the spending of their local tax dollars in pursuit of improved community health. The meetings of these publicly elected boards are open and subject to the provisions of the Ralph M. Brown Act, providing for public input and transparency in the boards' decisions. Currently, California has 79 Healthcare Districts, with 54 in rural areas of the state. Healthcare Districts provide a variety of health care services in their communities. In many instances, Healthcare Districts are the sole source of health and medical services in the community and serve as an integral part of the health care safety net. Each Healthcare District is unique, while focusing on the specific needs of their community.

As you are aware, there is a broad range of health care services provided by California's Healthcare Districts. As a result, it can be difficult to categorize them based on service provision. For ease of reference, we have categorized them into the following broad groups:

### District Hospital Designations

- **Health Professional Shortage Areas (HPSA)** is a federally designated area with specific thresholds of shortages of primary care, dental care, and/or mental health providers.
- **Critical Access Hospitals** are federally designated hospitals that meet specific criteria, including: 25 beds or less and located more than 35 miles from another hospital.
- **Frontier Hospitals** serve a population density of less than 11 persons per square mile and a geographic area without any incorporated community of greater than 50,000 people based on most recent federal census data.

There are currently 40 District Hospitals (operated by 38 Districts) in the state of California, primarily funded by reimbursed medical services that provide a variety of services. District Hospitals make up 20 of the state's 34 critical access hospitals, 26 of the state's 62 rural hospitals, ten of the state's 12 frontier hospitals, and 27 operate in a Health Professional Shortage or Medically Underserved Area.

District Hospitals vary significantly in size (from approximately 3 to 500 beds) and in the range of services provided. Many of these hospitals serve rural and semi-rural populations and are important Medi-Cal providers in their communities, as recognized in the Medi-Cal 2020 Waiver (see ACA section for additional details).

In addition to the 40 District Hospitals, there are five Districts that lease their hospital to an entity that oversees the day-to-day to operations. The lease agreements vary from community to community, with some Districts retaining responsibility for key infrastructure issues, such as seismic retrofit costs, and others placing seismic responsibilities on the lease management entity. Additionally, these lease agreements contain a commitment to continue to

provide a specific list of services. A handful of Districts have retained health care management companies to operate their hospital, with the District retaining ownership and the Board retaining oversight and responsibility for the hospital.

Of the 41 Districts that do not operate a hospital: 10 Districts never operated a hospital, and 16 hospitals have closed; 15 hospitals continue to operate, of those five are currently leased pursuant to Health & Safety Code 32121 section (p) and nine have been sold pursuant to Health & Safety Code 32121 section (p) and one is affiliated with a county health authority.

There are 21 Healthcare Districts that do not operate a hospital, including two of the five mentioned above that lease their hospital, but continue to provide direct health care services. These services include: operating stand-alone skilled nursing facilities, rural health clinics, community clinics, partnering with a federally qualified health center, providing stand-alone ambulance services, and providing preventative health services. Direct services provided by Healthcare Districts

**Each year, California's  
Healthcare Districts provide:**

- **1 million emergency room visits**
- **4 million in-patient hospital visits**

include: ambulance, community clinics, skilled nursing care, adult day care, chronic disease management, school health and physical education, non-emergency medical transportation, and other social services. In recognition that health care needs extend beyond the hospital, ten Districts were specifically created to provide health care services other than acute care; six were originally created to provide ambulance services.

There are currently 20 Districts that do not operate a hospital; including three of the five mentioned above that lease their hospitals. These Districts sold, leased, or closed their hospital at some point, or never operated a hospital. Many provide grants to community health-related non-profits, providing access to care that would not otherwise exist. Additionally, many of these Districts partner with local school districts to provide Healthcare services or nutrition/physical education to students. Community services supported by Healthcare Districts include: school health, nutrition, hospice, indigent care, senior care, and efforts toward reducing health disparities.

Most Healthcare Districts receive property taxes; however, there are thirteen Districts that are funded without property taxes. With the approval of voters, several Districts have levied special taxes for specific operating purposes and many have levied bonds for construction purposes. At least one Healthcare District received voter-approval of a bond to complete upgrades to meet seismic safety requirements for the hospital operated by a private sector entity through a lease agreement.

Much like those in California, Healthcare Districts across the country make access to quality care a priority in their communities. Palm Beach County Health Care District (Florida) operates a teaching hospital, nationally-recognized trauma system, school nurse program, and 120-bed skilled nursing facility. Both Wallowa County Health Care District and Lake Health District (Oregon) operate critical access hospitals, in addition to primary care clinics. Both Districts are members of the Oregon Association of Hospitals and Health Systems (OAHHS), which has 62 member hospitals. Arizona's Healthcare Districts are similar to California's in their diversity: Maricopa County Special Health Care District operates a pediatric emergency department, burn center, and dental clinic, in addition to their

hospital. Northern Apache Special Health Care District and White Mountain Communities Special Health Care District (AZ) offer necessary women’s health services, occupational therapy, and urgent care services at their primary care clinics. Similar to California’s Healthcare Districts, the Districts are funded in various ways, including fees, government and private insurance, property taxes, investments, interest, and grant donations.

### **How the ACA Impacts the Role and Responsibilities of Healthcare Districts**

California has embraced the ACA by expanding Medi-Cal eligibility and leading the nation in the development of a health insurance exchange. Healthcare Districts can play an important role in fulfilling the Triple Aim of the ACA:

- Improving patient experience of care, including quality and satisfaction
- Improving the health of populations
- Reducing the per capita cost of health care

Healthcare Districts – along with the rest of the health care community – are in the midst of transformation, partly in response to the changing state and national health care landscape and the delivery changes being generated by the Triple Aim. As health care focus shifts away from hospitals and toward preventative and primary care provided in outpatient settings, Healthcare Districts are rethinking their approach to care, including services beyond the walls of the hospital. Our members recognize that over the next five years, Medicaid reimbursement will focus more on value and outcomes. Likewise, Districts without hospitals are thinking about how their services and investments fit into the population health lens of the Triple Aim and how their programming will improve the overall health of the community.

Because Healthcare Districts are local, flexible, and can easily identify and fill gaps, they can provide access to care where there currently is little or none. Districts are best able to assess unique community needs and address those needs in a meaningful way. Consequently, Districts with and without hospitals have an important role to play in community health.

District Hospitals are important Medi-Cal providers, particularly in rural and underserved areas. More than a third of the District Hospitals provide over 30 percent of their care to low-income Californians, with some facilities treating as many as 50 percent low-income Californians. The state of California and the federal government recognized the important role of District Hospitals when they negotiated its newest Medicaid Waiver last year, including District Hospitals in that waiver. California received federal approval of a new Medicaid Section 1115 “Medi-Cal 2020” Waiver on December 31, 2015, which includes \$6.2 billion in federal funds over five years. The new waiver builds on the successes California has achieved in expanding coverage, transforming care, and improving health outcomes. Especially important to District Hospitals is the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a successor to the Delivery System Reform Incentive Program, that will provide \$466.5 million for District/municipal public hospitals and \$3.27 billion for county and University of California (UC) hospitals.

Medi-Cal 2020 marks the first time that District Hospitals will directly participate in a targeted improvement program under the Medicaid Waiver in California. District Hospitals will begin transformation work, improve

outcomes, and increase efficiencies over the next five years of the waiver. Consistent with state goals, PRIME is designed to support efforts to accelerate changes to care delivery to maximize health care value.

Almost all of the District/municipal public hospitals submitted PRIME applications in April that focus on at least one project in the three project domains: 1) outpatient delivery system transformation and prevention, 2) targeted high-risk or high-cost populations, and 3) resource utilization efficiency. District Hospitals can only receive federal funding if they meet specific established performance goals, which are the same as those for county hospitals and UC hospitals. By 2020, PRIME will result in the wide-spread adoption and sustainability of system transformations that will ensure District Hospitals deliver high-quality care to Medi-Cal beneficiaries. ACHD is pleased that District Hospitals will be part of the ambitious PRIME effort in support of the state's transformation of the health care system.

While this is not a requirement for District Hospitals, the county and UC hospitals will also have their PRIME payments linked to value-based payments in the later years of the waiver. Value-based payments are a national effort to link Medicare and Medicaid payments to the quality of care provided – in hospitals and by individual providers. The idea is to provide incentives to providers to improve health outcomes of Medicare and Medicaid beneficiaries. We anticipate that all Medicaid payments are heading toward more value-based payments and hospitals will be thinking about how to move toward value-based payments in the future.

Additionally, Districts are filling gaps in prevention and non-hospital care programs to underserved populations and to help improve the health of their communities. Here are a few examples where Districts are providing grant programs focused on community health:

#### **El Camino Healthcare District**

##### **\$738,700 on Community Based Mental Health Grants (2015-2016)**

El Camino Healthcare District grants include support for school-based mental health counseling, domestic violence services, initiatives to reduce depression and isolation in seniors, and treatment for underserved and homeless individuals with serious mental health conditions. The District funds programs to support students with behavioral health issues such as substance abuse, depression, bullying, and stress. In addition to student and family counseling services, the programs provide information on substance use prevention and education. In Fiscal Year 2014 – 2015 alone, programs funded by the District served over 2,200 people and provided more than 8,000 services. For Fiscal Year 2015 – 2016, the District awarded \$738,700 to community based mental health programs.

#### **Los Medanos**

##### **\$40,000 to sponsor a Breastfeeding Program (2013-2016)**

The District annually sponsors a Community Breastfeeding Program through a local non-profit, A More Excellent Way, in response to low birth rates, and higher infant mortality among African American and low income populations in their area. This project reduces health disparities and improves birth outcomes through prenatal care and lactation services for African Americans and low income individuals in Pittsburg and Baypoint, CA. The program serves 2,000 people in the District.

### **Desert Healthcare District**

#### **\$650,000 on Implementation of the ACA (2013-2015)**

In partnership with The California Endowment, the District combined funding with The Endowment for a total of \$1,184,924 that was granted to the Desert Healthcare Foundation for administration and campaign management to enroll individuals and families in Medi-Cal and Covered California. The project also leverages existing partnerships with trusted community non-profit and public agencies and targets the approximately 90,000 residents now eligible for Medi-Cal and Covered California.

### **Sequoia Healthcare District**

#### **\$205,000 on Treatment for Alcohol, Tobacco, and Other Drugs (2016-17)**

The District provided funds to El Centro de Libertad to provide assistance for youth requiring substance use disorder treatment and their families, of which 98% are low-income families. Funding is for substance use disorder treatment services and supports.

### **Fallbrook Healthcare District**

#### **\$35,000 on Medical Transportation (2015-16)**

Lack of transportation is a significant barrier to health care, for home-bound seniors. To help eliminate this obstacle, the District funded Foundation for Senior Care's Care Van Transportation Program which provides free, reliable transportation to medical and physical therapy appointments, grocery stores, food pantry, senior center, etc. for both ambulatory and non-ambulatory clients.

## **Emerging Challenges and Issues for Healthcare Districts**

California's Healthcare Districts face challenges similar to those faced by other public and private health care providers. Additionally, the heterogeneous nature of the services Healthcare Districts offer can inhibit understanding of Districts' role in a complex health care environment. For Districts with hospitals, primarily operating in underserved areas, there are a number of challenges that mirror those for health care providers generally. These include:

### **FINANCIAL ENVIRONMENT**

Health care operates in a highly competitive market. Much like other public and non-profit providers, District Hospitals struggle with low reimbursement rates for care, particularly for Districts that serve a high volume of uninsured and Medi-Cal patients. In many cases, the financial stressors on District Hospitals have forced their boards to turn to creative solutions to sustain health care services to the community. These innovative solutions include affiliation with private and/or public sector partners that can help fill gaps in terms of professional services, specialty services, financial and other management needs.

While District Hospitals are pleased to be participating in the Medicaid Waiver, and partnering with the state on the PRIME program, these projects are ambitious. All of the federal funds are contingent upon meeting universal, predetermined metrics for outcomes. If a hospital does not meet the metric requirements for its project, it will not

### **Primary Healthcare District Challenges and Issues**

- Financial Environment
- Workforce Retention and Development
- Community Engagement
- Fiscal Management
- State and Local Oversight

receive any federal matching funds. While District Hospitals will benefit from the work done by the county and UC hospitals in the previous Medicaid Waiver, the PRIME projects will undoubtedly be challenging for the District Hospitals. In many cases District Hospitals do not have extensive networks of outpatient, clinic, and specialty services; as a result, the Waiver may result in additional partnerships in areas where such opportunity exists.

Some District Hospitals have struggled under financial pressure, mostly due to the inability to achieve a viable payer mix to ensure survivability as a stand-alone hospital. For example, in 2015 West Contra Costa Health Care District was unable to make ends meet financially, due in large part to their high volume of uninsured, underinsured and Medi-Cal patients served; as a result, they closed their doors permanently. Additionally, Palm Drive Health Care District closed temporarily due to a longstanding challenging economic environment, and reopened in 2015 after significant reorganization. While the District has been able to reopen the hospital, it continues to struggle.

### **WORKFORCE RETENTION AND DEVELOPMENT**

A significant challenge faced by District Hospitals is the recruitment and retention of health care providers. While health care workforce development is a substantial challenge on a statewide basis, as there is a lack of physicians statewide, especially primary care, and maldistribution of physicians currently, there are unique and significant challenges for Healthcare Districts operating in rural and underserved regions of the state. In many of these communities, it is simply not financially feasible for physicians to relocate and set up a practice, particularly for specialty care practices. Districts are further challenged by the aging of the existing workforce, with a considerable number of existing physicians nearing retirement age.

Not only is it a financial challenge to live and work in a rural or underserved community generally, Healthcare Districts are the only public agencies that are prohibited by law from directly hiring physicians. (The State of California, University of California, and county hospitals are authorized to directly hire.) Our experience indicates that potential recruits in these communities are not interested in establishing independent medical practices and would prefer to seek full-time employment. As a result, District Hospitals are at a substantial disadvantage when attempting to recruit physicians. ACHD supports a number of solutions to address this issue, including Assembly Member Jim Wood's AB 2024 (2016), which would authorize federally certified critical access hospitals (of which 20 are District Hospitals) to directly employ physicians on a pilot basis.

### **COMMUNITY ENGAGEMENT**

While Healthcare Districts with hospitals experience a set of challenges that result from the direct provision of health care in the community, all Healthcare Districts experience challenges associated with their role as public agencies serving a constituency. California's Healthcare Districts are continually challenged – like most special districts in the state – to ensure relevance and awareness among its constituency and to provide a community value to taxpayers. To assist in facilitating sharing of best practices and improvements in community engagement, ACHD's newly created working group has been focusing strategies to assist Districts in reaching out to stakeholders in the community. In addition, we know that we have work to do to ensure that all stakeholders, including state legislators, have an understanding of Districts' roles in providing needed health care services to local communities and where they fit into the local health care system.



This is a particular challenge for those Districts that provide an important financing and infrastructure mechanism to promote community health but do not provide direct health care services. About 36 Healthcare Districts no longer own, operate a hospital or, ever had a hospital. Of these, eight operate ambulance services, five own or operate clinics, four operate skilled-nursing facilities, preventative/wellness care, and community health, while others provide grant programs. We acknowledge questions raised by members of the Legislature about the purpose of these Districts; however, this may result from a more narrow view of health care. As mentioned previously, these Districts provide a broad range of non-hospital services, including school health and nutrition, chronic disease management, elder care, CPR education, and meet other identified community needs.

### **FISCAL MANAGEMENT**

As to the receipt of property tax revenues, some but not all Healthcare Districts receive property tax revenues, depending on what has been approved by voters. In the case of Districts operating hospitals, property tax revenues generally represent a very small portion of overall revenues received by the District and used for operations. For those not operating hospitals, property tax revenues represent a larger component of the revenue mix. On the issue of reserves, Healthcare Districts use reserves generally for capital projects, to assist in meeting cash flow needs, and to establish a contingency fund for future liabilities. For those Districts that have leased their hospitals to another entity, it is vital for those Districts to maintain a level of reserves should the District be required to directly operate those facilities or services in the future. For example, in some cases where the District no longer operates the hospital, the District will require working capital and the financial wherewithal to maintain ongoing operation of the hospital if the non-profit or private operator ceases to provide service.

### **STATE AND LOCAL OVERSIGHT**

ACHD strongly believes that decisions regarding local agency governance, services, and use of resources are best made at the local level. State law, in fact, makes Local Agency Formation Commissions (LAFCO) responsible for orderly formation and development of local agencies based on local conditions and circumstances. Governed by local elected officials, LAFCOs are best suited to evaluate the needs of the community and the efficacy of the local agencies that are tasked with providing community services. Further, the LAFCO process is open and public, designed to be a deliberative process with broad stakeholder participation. That said, we recognize there may be challenges for LAFCOs and Healthcare Districts alike in collaborating on mandated reviews. Healthcare Districts want to work with LAFCOs to improve this process, and are currently discussing options for doing so in the context of our working group.

In terms of the Legislature's role in addressing concerns with Healthcare Districts, or any special district, we have strongly suggested that the Legislature refrain from legislation addressing a concern about a specific Healthcare District until a local process and dialogue has taken place. We have expressed our strong concerns with legislation aimed at dissolving or otherwise managing a District without a local conversation first. Doing so undermines the role of LAFCOs at the local level and bypasses the important stakeholder process that allows for more informed decision-making. Further, while Healthcare Districts do not exist in every legislative district in the state, it is important that the Legislature have a better understanding of the role of Healthcare Districts in the provision of health care services throughout the state. We agree that both the Association and our members can do a better job



at communicating the roles and responsibilities of Healthcare Districts to the public at large, including members of the Legislature and other state officials.

Our working group effort may also result in the need for statutory changes to the Healthcare District authorizing statute. In these instances, where we anticipate the need for modernizing and updating the enabling act in the Health and Safety Code, ACHD would respectfully request the Legislature's assistance in achieving such changes. Additionally, ACHD is committed to working with stakeholders, including the California Special Districts Association, the California Association of Local Agency Formation Commissions (CALAFCO) and others in this process.

## **Model Healthcare Districts**

Healthcare Districts are best situated to respond to the changing health care needs of the local communities they serve. Healthcare Districts work collaboratively with other local provider stakeholders to determine programs and services to fill local needs. Below are some examples of Healthcare Districts leading the way on community needs assessments, filling the health care gaps in their community, and implementing innovative approaches to health care.

### **ASSESSING COMMUNITY NEEDS**

***Desert Healthcare District*** works with local community partners to conduct a health status assessment of its residents every three years. The District uses this information to focus their grant-making efforts, to create sustainable health care programs, and to identify needed projects. The District provides an annual report to the community on the grant funds given and the outcomes of those grants, projects funded by the District, and other financial information.

***Palomar Health*** collaborates with other health systems, government agencies, and community groups to identify the greatest needs in their community. The District reports to the community annually on the health improvement activities provided throughout the fiscal year to ensure accountability to the District on the greatest needs identified in the needs assessment.

***El Camino Healthcare District*** uses the El Camino Hospital Community Health Needs Assessment (CHNA), a multi-year evaluation of the health of the community that is developed in collaboration with six other non-profit hospitals, Santa Clara County Public Health Department, the Hospital Council of Northern and Central California, and Palo Alto Medical Foundation. The documented health needs identified in the triennial assessment are formally prioritized and selected by an advisory council comprised of physicians, representatives from the community, El Camino Hospital or El Camino Healthcare District Board members, and senior management staff. The needs are mapped to health priority areas and serve to inform the District's Community Benefit grant making process. The CHNA is made available to the public in a full written report available on the healthcare district's website. Additionally, the District releases an annual report, organized by the health priority areas, that outlines Community Benefit activities, funds awarded, and quantitative and qualitative results for community impact.

## FILLING GAPS

**Camarillo Health Care District** established a senior nutrition program for their community. The District, in partnership with the Ventura County Area Agency on Aging (VCAAA) and City of Camarillo, provides residents age 60 and over with two meal program options. A monthly catered meal at the Health Care District and a “meals on wheels” look-a-like program offering ready-to-heat frozen entrees delivered by volunteers three times per week.

**Petaluma Health Care District** was the lead agency that established the Petaluma East Side Farmers’ Market and the Local Incentives for Food and Economy (LIFE) program in 2012. Despite its rich agricultural history, fresh healthy food can be out of reach for many Petaluma Health Care District (PHCD) residents. This nutrition program was created to address this health concern. Overseen by a non-profit, Petaluma Bounty, the LIFE program provides a dollar for dollar match, of up to \$10, for CalFresh (food stamp) clients to purchase healthy produce at the Farmers’ Market. In total, the District has provided over \$8,000 in matching funds to the LIFE program which empowers residents to purchase healthy locally produced food. In 2015, the District provided additional funds to secure a federal grant that expanded the LIFE program to all four Farmers’ Markets with PHCD’s territory, plus four additional Sonoma County markets.

**Desert Healthcare District** started a mobile dental program in 2000 in light of a terrible shortage of dentists in their District, especially those who would accept Medi-Cal for payment. The Smile Factory is a 53-foot mobile dental clinic used to provide free screenings and dental treatment to children in need. That program was taken over by a local health care nonprofit and still used to this day.

**Peninsula Health Care District** acquired a new Center for Dental Health and mobile dental outreach to their District, which is the first of its kind on the West Coast. The District entered into a 10-year public private partnership agreement with Apple Tree Dental, providing assisted tenant financing, equipment, and operating capital through a \$2 million impact grant. Apple Tree Dental provides high quality dental care to all ages, incomes, and cognitive status. In addition to offering general restorative dentistry and specialty care at its clinic location, this program also provides dental treatment in nursing care institutions, assisted living facilities, group homes, and schools.

**Mayers Memorial Hospital District** operates a frontier critical access hospital in Shasta County providing emergency, inpatient services, skilled nursing and long-term care facilities to the intermountain area of California. The next nearest hospital is 70 miles away and the closest skilled nursing facility is 75 miles away. Without this District Hospital, these services would cease to exist, as no other provider would be able to provide such services on a for-profit basis.

## INNOVATING NEW APPROACHES

**Kaweah Delta Health Care District** created a new medical residency program in 2012 with two programs, family medicine and emergency medicine. Faced with physician recruitment challenges in the Central Valley, the District created the program to improve access to health care in the District. Kaweah Delta now offers five residencies in family medicine, emergency medicine, psychiatry, surgery, and transitional year. In 2016, the first class of physician

residents graduated and more than 40 percent of the original class of residents have remained in the Central Valley.

***Petaluma Health Care District*** created a community advisory committee, The Community Health Initiative of the Petaluma Area (CHIPA), in partnership with the County's health initiative. CHIPA provides leadership in identifying community health priorities and taking action to engage in policy, system, and environmental change to improve local health. This is accomplished through collaboration and partnerships with key community, health care and business leaders, local capacity building, and alignment with County goals. To date, CHIPA has more than 60 members representing a diverse cross-sector of their community. Current members include: business leaders, local non-profits and service providers, schools, early childhood educators, county employees, health care providers, police, city officials, farmers, and community residents.

### **Healthcare Districts Looking Forward**

ACHD's working group has already identified potential opportunities for the Association and Healthcare Districts to consider in the upcoming year. As referenced earlier, we will continue to have discussions regarding the Healthcare District enabling act, possibly lead to the development of a standard community needs assessment and community benefits report requirement, partnering with CALAFCO to develop a more consistent and productive working relationship between LAFCOs and Healthcare Districts statewide, and additional efforts aimed toward educating the community and the Legislature on Healthcare Districts' role in our health care system. We will continue to focus our energy on achieving meaningful reforms that provide Healthcare Districts with support and assistance in meeting their missions, as well as connect Districts more closely with their community partners. We look forward to sharing the results of these efforts as they progress.

ACHD would be happy to provide additional information to the members and/or staff of the Little Hoover Commission. We appreciate the opportunity to participate in this important discussion.